PM FORM 4.3.2
REQUEST FOR INFORMATION FROM PCP

TO:
PCP Name:
Address:
Phone #:
Fax #:

FROM:
Behavioral Health Provider Name:
Address:
Phone #:
Fax #:
Contact Name:
Contact Phone #:
Contact Title:

Dear Care Provider:
The above behavioral health provider is writing to request information that concerns one of your patients for the purpose of coordinating care. The quality of care that this person receives is dependent on your timely response to this request. **Confidentiality laws do not require a separate authorization to release this information.** If you have questions regarding this request, please contact the above referenced person.

RE: Patient Name:
Patient Date of Birth:

AHCCCS ID#:
Health Plan Name:

Please send the following information regarding this patient:

☐ Mailed By (Print name):
☐ Faxed

_____ Date:
Signature

Note: Retain copy in person's comprehensive clinical record

Effective Date: 10/15/2004
Last Revised: 09/03/2004